



**MEDICARE**  
**Electronic Data Interchange**

**FIRST COAST SERVICE OPTIONS, INC.**  
**MEDICARE PART A**  
**COMPUTER SECURITY ADMINISTRATION**  
**DDE USER ID COMPLIANCE STATEMENT**

This DDE User ID Compliance Statement, entered into this \_\_\_day of, \_\_\_\_\_, \_\_\_\_\_ is by and between First Coast Service Options, Inc. (hereinafter "FCSO"), located at 532 Riverside Avenue, Jacksonville, Florida 32202 and \_\_\_\_\_(hereinafter "we" or "Provider") located at\_\_\_\_\_.

We, the undersigned, hereby request receipt of the DDE USER ID, which will be used to gain access to the FCSO, Medicare Part A, network to perform Medicare Part A Direct Data Entry functions.

We agree to:

1. Be responsible for all activities logged under this DDE USER ID.
2. **Do not share or exchange this DDE USER ID or password.**
3. Report to Computer Security Administration any suspected misuse of the DDE USER ID.
4. Use the system to perform tasks only for First Coast Service Options, Inc. business.
5. Follow established corporate policy as described in the Corporate Computer Information Security Policy.

Non-Compliance with the above is considered to be unacceptable behavior, which will be cause for FCSO to revoke access to the Direct Data Entry (DDE) system.

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**In accordance with FCSO Corporate Computer Security Policy, your DDE USER ID is not to be used by anyone other than yourself. Also, your password is not to be revealed to anyone, including Supervisors and Managers. This DDE USER ID will remain with you as long as you are employed by the aforementioned facility as FCSO Computer Security monitors all of your activity. If at any time you believe that someone has used your DDE USER ID, or someone asks you to reveal your password, contact Medicare Part A, DDE Support, at (888) 670-0940, option 3.**

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**PLEASE FAX BOTH PAGES TO:  
MEDICARE PART A, DDE SUPPORT  
FAX # (904) 361-0430**

**DDE USER ID COMPLIANCE STATEMENT**

\*All fields required unless otherwise noted as optional

MEDICARE PART A PROVIDER # (if known) \_\_\_\_\_ DATE: \_\_\_\_\_

\*National Provider Identifier (NPI) \_\_\_\_\_

1. Please list below the name(s) of your facility employee(s) that need a DDE USER ID:

NAME (Please Print)	SIGNATURE	4 Digit Pin (generally the last four of SSN)	Current DDE USERID

**All information supplied will remain confidential between the Provider and FCSO.**

2. If applicable – If you access multiple providers, please list individual NPI number(s) below:  
**(optional)**


3. If applicable - Please list below the name(s) of your facility employee(s) that no longer need access to DDE. **(optional)**

NAME (Please Print)	EMPLOYEE ID #/ SSN #	DDE USER ID

\*Signature Approval: \_\_\_\_\_

\*Please Print Name/Title: \_\_\_\_\_

\*Email: \_\_\_\_\_ \*Date: \_\_\_\_\_

\*Phone #: \_\_\_\_\_ \*FAX #: \_\_\_\_\_